American Medical Association

Physicians dedicated to the health of America

AMA Physician Profile Unit
515 North State St
Chicago, IL 60610

Telephone: 312 464-5199
Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA) at the above address. Profiles also can be ordered online through ***AMA ePhysician Profiles*** located at http://www.ama-assn.org/AMAPhysicianProfiles. AMA Customer Service is available for ordering assistance at 800-665-2882 or 312-464-5199, Monday through Friday, 8:30am - 4:45pm CT.

******Join or renew your AMA membership today---call 800-AMA-3211******

Indicate AMA Membership Status: _____Member Physician _____Nonmember Physician

Membership Type	**Standard Mail Service*** (within 10 business days)	**Express Service*** (within 5 business days)
AMA Member Physician	No charge	$6 per profile
Nonmember Physician	$26 per profile	Not available

****Prices are subject to change without advance notice.***

Credit card payment is accepted. Checks should be made payable to the American Medical Association, Remittance Control Area/PPS, Accounting Department, PO Box 109054, Chicago, IL 60610. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount**: $**_____

Credit Card Number _____Expiration Date: ____/____/____

Name on Credit Card: _____

Billing Address:_____

Approval Signature_____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing or medical specialty board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

_____
Physician Name (first, middle, last, suffix)

_____ ____/____/____ _____
Place of Birth Date of Birth Social Security Number

_____ _____
E-mail Address Medical Education Number (optional)

_____
Preferred Mailing Address

_____ (_____)_____-_____
City, State, Zip Code Telephone Number

The above address is my OFFICE ___ HOME ____ OTHER ___

If address is home or other, please complete this section.

_____
Primary Office Address

_____ (____)_____-_____
City State Zip Code Office Telephone Number

Part 3: Medical Education and Other Information

Medical School of Graduation _____ Year of Graduation _____

DEA Number _____ ECFMG Number _____

Residency Training

Residency Training (institution/hospital name, location, and years) _____

_____

_____

Hospital Admitting Privileges

Hospital Name	City/State
_____	_____
_____	_____
_____	_____

Group Practice Affiliation(s)

Group Practice Name	City/State
_____	_____
_____	_____
_____	_____

Physician Agreement

Agreement must be signed in order to process your request.
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X_____ _____/_____/_____
Signature Date